6.b. OPTOMETRIC SERVICES

Limitations:

1. Routine refractive services and optical devices are available annually, without prior approval to individuals eligible for EPSDT.

2. Medical diagnostic services which aid in the evaluation and/or diagnosis of ocular diseases are covered regardless of the recipient's age. Practitioners must have the training and license required by State law.

3. Routine refractive services or optical devices provided in a nursing home must be specifically requested by a recipient's attending physician.

4. Optical devices, with the exception of contact lenses, devices for retinitis pigmentosa and customized prosthetic eyes are provided through contract with a single source supplier.

5. Post-cataract surgery follow-up care provided by an optometrist is covered if the recipient is referred in writing by the surgeon. The optometrist will not be reimbursed for follow-up care until the referring surgeon's fees has been paid.

6. Covered optometric services will include any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of their practice as defined under State law.

Prior Approval is required for the following:

1. Eyeglasses with both lenses of less than $\pm$ 1.00 diopter, in any meridian.

2. Lenses with less than a $\pm$ 1.25 "Add."

3. Contact lenses, regardless of diopter.

4. Replacing or dispensing optical devices within the same calendar year.

5. Refractive examination within the same calendar year that the recipient last had a refractive exam.

6. Customized prosthesis (stock eyes are covered without prior approval).

TRANSMITTAL 92-33
APPROVED 10-22-92
EFFECTIVE 10-01-92
SUPERSEDES 92-20

OPTOMETRIC SERVICES (Continued)

7. Ultraviolet tint for prosthetic lenses and/or goggles for retinitis pigmentosa, albinism, and aphakia.

8. Change of eyeglass prescription when the power of the axis is less than 5 degrees or a 1/2 diopter change in sphere or cylinder power. New lenses must also improve visual acuity by at least one line on a standard acuity chart.

9. Oversized Frames (Flatter Fit)

10. Trifocal Lenses

11. Slab off lens(es)

12. Hi-index plastic lenses (for prescription of less than $\pm$ 6 diopters)

13. Polycarbonate lenses

Non-Covered Services

1. Tinting lenses (except for albinism and retinitis pigmentosa).

2. Vision therapy.

3. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Services as universally accepted treatment.

4. Routine refractive services and optical devices provided for recipients twenty-one years of age or older.

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SUPERSEDES 92-20

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Chiropractors' services.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

d. Other practitioners' services.

[X] Provided: Identified on attached sheet with description of limitations, if any. Psychologists' Services

[ ] Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [ ] No limitations [X] With limitations*

b. Home health aide services provided by a home health agency.

Provided: [ ] No limitations [X] With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: GEORGIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

8. Private duty nursing services.

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

*Description provided on attachment.

Voided as of 3/29/02 apt

6.d **OTHER PRACTITIONER'S SERVICES**

A. PSYCHOLOGIST SERVICES

Limitations:

1. Medically necessary psychological services are provided only to EPSDT eligible individuals.

2. Psychological services are limited to 24 hours (48 units) per calendar year per recipient. Exceptions to this limitation are considered only upon written appeal.

Coverage of psychological services is limited to those providers fully and permanently licensed by the State Board of Examiners of Psychologists as required by Title 43, Chapter 39, of the Official Code of Georgia Annotated and Chapter 510 of the Rules and Regulations of the State of Georgia.

6.d. OTHER PRACTITIONER'S SERVICES

B. NURSE PRACTITIONER SERVICES

Limitations:

1. The scope of service for certified Pediatric Nurse Practitioners is the management and care of children up to 18 years of age for primary and preventive health care. The scope of service for certified Family Nurse Practitioners is the management and care of children and adults for primary and preventive health care.

   The scope of service for certified OB/GYN Nurse Practitioners is the care of children and adults for OB/GYN services. The scope of service for Certified Registered Nurse Anesthetists (CRNA) is the management and care of children and adults for anesthesia services.

   The scope of service for certified Adult Nurse Practitioners is the management and care of adults for primary and preventive health care.

   The scope of service for certified Gerontological nurse practitioners is the management and care for geriatric adults for primary and preventive Health care.

   Providers must be currently licensed as registered professional nurses, be currently certified as Pediatric Nurse Practitioners, Family Nurse Practitioners, OB/GYN Nurse Practitioners, Adult Nurse Practitioners, Gerontological Nurse Practitioners or certified Registered Nurse Anesthetists, by the appropriate certifying body and be registered with the Georgia Board of Nursing for the specialty.

2. The Medicaid program will not provide reimbursement to a nurse practitioner for the following:

   a. office visits which exceed 12 per recipient per fiscal year unless medically justified.
   b. nursing home visits which exceed 12 per recipient per fiscal year unless medically justified.
   c. more than one hospital visit per patient per day of hospitalization, except when additional visits can be medically justified and approved.

3. Reimbursement for injectable drugs is restricted to those listed in the Physician's Injectable Drug List.

Prior Approval

More than twelve medically necessary office or nursing home visits per year (July 1 through June 30) for any one recipient.

Non-Covered Services

1. Services provided by a portable x-ray service.
2. Laboratory services furnished by the State or a public laboratory.
3. Experimental services, drugs or procedures which are not generally recognized by the advanced nursing profession, the medical profession or the U. S. Public Health Service as acceptable treatment.
4. Any procedure outside the legal scope of Pediatric, Family Health, Adult, Gerontological, OB/GYN or CRNA practitioner services.
5. Services not covered under the physicians' program.

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APPROVED 4-12-94
EFFECTIVE 1-1-94
SUPERSEDES 93-039

6.e. AMBULATORY SURGICAL CENTER SERVICES

10-1-87 Ambulatory surgical center (ASC) services are covered under section 1905(a)(18) as any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary.

Limitations

7-1-89 Services are limited to those surgical procedures which are covered by Medicare and which have been identified by HHS pursuant to 42 CFR 416.60-75, and to those surgical procedures deemed cost effective by the Department.

Services are provided by distinct entities that operate exclusively for the purpose of providing surgical services to eligible recipients not requiring hospitalization.

Services are furnished to outpatients.

Services are furnished by facilities that meet requirements in 42 CFR 416.25 through 416.49.

Ambulatory surgical centers are recognized by state law under OCGA Section 31-7-1(1)(D).

TRANSMITTAL 91-45
APPROVED 3/27/92
EFFECTIVE 11/1/91
SUPERSEDES (NEW)

7. HOME HEALTH SERVICES

MEDIAI

Limitations

a. Services are provided by Medicare certified home health agencies which have met all conditions of participation.

b. Nursing visits (as defined in the State Nurse Practice Act) and visits rendered by home health aides who are working under the direction and supervision of a registered nurse, are provided up to 75 visits per recipient per calendar year. Accrued visits for physical, occupational or speech therapy are included in the 75 visits.

c. Medical Supplies: Reimbursement for medical supplies furnished by home health agencies is included in the per-visit reimbursement rate.

Equipment: All equipment must be prescribed by a physician or individual practitioner authorized under State law to prescribe such equipment. Equipment must be obtained from qualified providers through the DME program. Covered equipment must be appropriate for home use, be able to withstand repeated use, and be medically necessary. One-to-two months' short-term rental may be provided without prior approval. Subsequent monthly rental must be prior-approved.

Appliances: All appliances must be prescribed by a physician or licensed practitioner authorized under State law to prescribe such appliances. Covered items include orthotic equipment and prosthetic devises. Appliances are obtained through the O&P Program.

prov

d. Physical, speech, and occupational therapy are provided.

e. Patient admission to the Home Health Program shall be based on the Department's review of the information on the "Agency Recommendations and Patient Profile" (DMA-44) and the physician's orders to determine if the recipient meets the departmental requirements for reimbursement of home health services based on established criteria.

f. Community Care Service Program (CCSP) recipients can also receive home health services. Admission shall be based on the CCSP assessment team's determination on the "CCSP Level of Care and Placement Instrument" (Form 5588) and physician's orders to determine if the recipient meets the Departmental requirements for reimbursement of home health services based on established criteria.

Non-Covered Services

Social Services (medical social consultation).

Chore services (Homemakers).

Meals on Wheels.

Audiology Services.

Visits in excess of 75 per recipient per calendar year. Visits in excess of 75 may be provided for EPSDT eligible recipients if medically necessary and prior approval is obtained.

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SUPERSEDES ~~91-048~~ 92-21

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

9. CLINIC SERVICES

MENTAL HEALTH CLINICS

Limitations

Outpatient mental health clinics meet the standards prescribed in the Division of Mental Health Policy Memorandum 40-01. Services are provided to eligible recipients who are emotionally or mentally disturbed, drug or alcohol abusers, mentally retarded or developmentally disabled. Available services are:

Partial hospitalization. Limited to extensive outpatient care and shall not include stays of twenty-four (24) hours or more.

Day Treatment.

Methodone Maintenance.

Individual therapy--includes diagnostic assessment, family therapy and crisis management.

Group therapy--includes ambulatory detoxification.

Psychiatric/medical assessment.

Special services--includes physical, speech, hearing and occupational therapies.

Non-Covered Services

Mental health services provided by outpatient community mental health centers to patients at their residences or in institutions such as skilled nursing or intermediate care facilities and residential care facilities.

FAMILY PLANNING CLINICS

See Attachment 3.1-A, page 2a for a description of Family Planning Services and Limitations.

(Clinic Services continued on page 4a-1)

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